DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY DENTAL ACTIVITY
FORT HUACHUCA, ARIZONA 85613-7040

REPLY TO
ATTENTION OF

DSBJ-CDR (1oo) 13 December 1999

MEMORANDUM FOR ALL DENTAC PERSONNEL

SUBJECT: U.S. Army Dental Activity (DENTAC) Policy Letter #00-03 -- Policy on Endodontic Care to Local Civilian Dentists

1. Purpose. To provide policy and procedures for referral endodontic care for soldiers to local civilian dentists.

2. Policy.

a. This procedure is authorized only for active duty soldiers assigned to USAIC&FH.

b. The decision to refer will occur only after thorough discussion between referring dentist and patient, and the mutual decision and agreement on the necessity to obtain a post-endodontic, final restoration. Before referral, patients will demonstrate acceptable levels oral hygiene.

3. Procedures.

a. Referring dentist assigned to the Fort Huachuca DENTAC will prepare DD Form 2161 (encl 1), completing the "Reason for Request" and "Provisional Diagnosis."

b. Team administrative staff will do the following:

(1) Make an appointment with the civilian endodontist.

(2) Emphasize to the patient, by written agreement, the importance of keeping this appointment (encl 2).

(3) Provide a strip map to the patient showing office location (encl 3).

(4) Prepare MMSO Claim Form for the patient (encl 4).

(5) Fax a copy of the DD Form 2161 to the DENTAC secretary, and provide the original to the patient.

Policy letter #00-03 supersedes #99-16, dated 12 May 99

(6) Place a copy of the DD Form 2161 in the patient's dental record and maintain a suspense log of referred patients.

c. The civilian dentist's administrative staff will do the following:

(1) Obtain the signature of the soldier on the MMSO Claim Form, block 10, verifying he/she has received dental treatment.

(2) Mail the MMSO Claim Form, bill for treatment, and completed DD Form 2161 rendered to the following address:

Commander
U.S. Army Dental Activity
ATTN: DSBJ-CDR (Mrs. Price)
Fort Huachuca, AZ 85613-7040

d. The DENTAC commander will review the referral and claim forms to determine if the charges are appropriate. If so, then will sign off on the MMSO Claim Form, block 11, and forward to the DENTAC secretary.

e. The DENTAC Secretary will do the following:

(1) Before the patient has received treatment, the secretary will fax the DD Form 2161 to the Military Medical Support Office at Great Lakes, Illinois, (847) 688-7394, then follow-up with a call ((888) 647-6676, ext 711 or 714)) to obtain the prior approval number.

(2) After the patient has received treatment and upon receipt of the completed DD Form 2161 and accompanying MMSO Claim Form, the secretary will then mail or fax the provider's invoice, the DD Form 2161, and MMSO Claim Form to Great Lakes for payment directly to the provider.

4 Encls

HARLAND G. LEWIS, JR.
Colonel, Dental Corps
Commanding

REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO: ☒ REFERRING UNIFORMED SERVICES FACILITY ☐ CHAMPUS

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST
Dr. Don Robertson	U.S. Army Dental Activity, Fort Huachuca	Enter date

REASON FOR REQUEST *(Complaints and findings)*

Chief complaint: in the patient's words

History: symptoms, duration, rapidity of symptom onset, previous involvment, other lesions, lymph node enlargement Y/N, probable etiological factors, etc.

Signs: radiolucency Y/N, sensitivty to percussion and/or temperature, mobility, root resorption Y/N, etc.

ANTICIPATED LENGTH OF TREATMENT

PROVISIONAL DIAGNOSIS

tooth #: irreversible pulpitis/periapical periodontitis/etc.

DOCTOR'S SIGNATURE	APPROVED *	PLACE OF CONSULTATION		
			☐ ROUTINE	☐ TODAY
Dental Officer	Team Leader or OIC	☐ BEDSIDE ☒ ON CALL	☐ 72 HOURS	☐ EMERGENCY

CONSULTATION REPORT

Filled in by Dr. Robertson

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
(Dr. Robertson's Signature)			
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade, rank; rate; hospital or medical facility)*

DD FORM 2161, 1 OCT 78

USAPPC V1.00

Team admin staff fills in this section

PATIENT RESPONSIBLE FAMILY MEMBER SIGNATURE ________________

SPONSOR'S FULL SSAN 123-45-6789

IMPORTANT INFORMATION *(on reverse side)*

APPROVAL

* Signature of Commander or designated representative must appear in "approved" block on front of form.

PATIENT INFORMATION

As you have been advised, your physician has determined that you require the medical services shown in the front of this form. These specific services are not available at this medical facility. After considering other sources of care available for you, your physician has recommended that you get the medical services you need from local civilian sources. The Uniformed Services regulation covering payment for civilian medical care requires that claims for the civilian care recommended by your physician be sent to:

a. ☒ THIS MEDICAL FACILITY. Charges to you will be the same as if you received the care in this facility.
b. ☐ CHAMPUS. Charges to you will be as prescribed under current terms of the CHAMPUS program.

The Health Benefits Coordinator at this facility will answer any questions you have concerning this determination.

If the charges are being submitted for CHAMPUS consideration, insure that the Health Benefits Coordinator fully explains program cost-sharing provisions. Allowable charges, provider participation, and claim filing procedures for your particular case. You should also:

a. Make arrangements to see the type of civilian provider recommended by your physician at this facility.
b. File your CHAMPUS claims regularly (every 30 days). Attach a copy of this form with each CHAMPUS claim submitted for care recommended.
c. Your signature on the front of this form indicates your understanding of how payment will be made for the medical services recommended on the front of the form.

INFORMATION FOR CIVILIAN PROVIDERS ON CARE

This patient is being referred to you for the services indicated on the front of this consultation sheet. Your charges should be submitted to:

☒ U.S. Army Dental Activity, Fort Huachuca — Please send your itemized

NAME OF THE UNIFORMED SERVICES MEDICAL FACILITY

bill with this completed consultation sheet to:

Complete mailing address of referring medical facility:

Commander
U.S. Army Dental Activity
ATTN: DSBJ-CDR (Attn: Ms. Price)
Fort Huachuca, AZ 85613-7040

NOTE: Use provided pre-addressed envelope for return of consultation report.

☐ CHAMPUS. (1) Conditions for participation in the CHAMPUS program are described on the CHAMPUS claim form. We encourage provider participation. Participating providers should send properly completed claims to:

Address of CHAMPUS Contractor for your area

Send completed consultation report to:

NOTE: Use provided pre-addressed envelope for return of consultation report.

If you elect not to participate in the CHAMPUS program, please give the patient an itemized statement of your services, including diagnostic information (ICDA or DSM II is acceptable). The patient is responsible to you for payment arrangements. CHAMPUS payment will be made to the patient.

Health Benefits Advisor signature ______________________________

PLEASE INCLUDE A COPY OF THIS COMPLETED CONSULTATION SHEET WITH EACH CHAMPUS CLAIM YOU SUBMIT TO THE CONTRACTOR.

USAPPC V1.00

ENDODONTIC -- ROOT CANAL -- REFERRALS

1. The Fort Huachuca DENTAC is now referring certain root canal cases to a civilian specialist. If this program works, patients will rarely be sent to William Beaumont Medical Center, El Paso, Texas. This is a great convenience for our military patients.

2. It is extremely important that you report for your appointment on time, or that you personally cancel your appointment a minimum of 24 hours prior to your scheduled appointment.

3. Your full cooperation is appreciated.

PATIENT SIGNATURE: ____

Sierra Vista Endodontics
Cochise Vista Plaza, Suite 103
2151 South Hwy 92
Sierra Vista, AZ 85635
520-417-0311

Don C. Robertson , DDS, MPH, MS
Practice Limited to Endodontics

Date_______ ________

Patient's Name___ ___________________ _______________

Referred by Dr.______________________________ ___

Phone #______ _______ ________ _______________

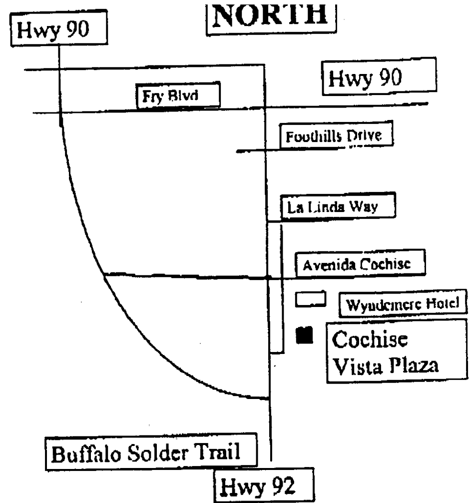
Right															Left
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Please evaluate and perform the following:

☐ Consultation and diagnosis ☐ Endodontic Therapy
☐ Surgical Endodontics ☐ Prepare post space
☐ Provide Post ☐ Post/core buildup

Buildup Material: ☐ Composite ☐ Alloy
Other__ _______ ________

Comments:________ ________ ______ ________



Sierra Vista Endodontics
Cochise Vista Plaza, Suite 103
2151 South Hwy 92
Sierra Vista, AZ 85635
520-417-0311

1. Patient's LAST NAME, First Name MI.	2. Pay Grade / Rank	3. Social Security #
________ ________ ___	______ /______	________

4. Branch of Service:

USA USN USMC USAF Other: ________

USAR* USNR* USMCR* USAFR*

Army NG (Active) Army NG (Inactive)* Air NG (Active) Air NG (Inactive)*

* For service members in an Inactive Duty status, appropriate eligibility documentation must be provided if treatment has been found to be a result of a service-connected injury.

5. Current Duty Station (work location)	6. Patient's Home Address:
Command ______ UIC ______	Street Address ______
Street Address ______	City ______ State ______ Zip Code ______
City ______ State ______ Zip Code ______	Home phone number (with Area Code) ______

7. Type of Care:

Emergency Treatment Routine Prior Approval Number issued by MMSO:

\# ________________

8. Did a Military Dental Clinic authorize the referral of this care? Yes No

Name and location of referring dental clinic: **Runion Dental Clinic, Fort Huachuca, AZ 85613-7040**

9. Has bill been paid? YES NO

If Yes, In Full In Part

If service member paid, a SF 1164, Claim for Reimbursement with the member's original signature and proof of payment must be submitted with this claim.

10. Service member's signature: I certify that I received this care and the information provided is accurate. I authorize release of health care records related to this care.

________________ ________________
Signature Work Phone Number (with Area Code)

11. As/For the Commander of the above named service member, I certify that this individual is eligible for this care at government expense.

________________ Signature	Harland G. Lewis, Jr., COL, DC Printed Name (CO, Senior Officer, MEDREP, or HBA)	(520) 533-3144 Phone Number